KENTUCKY BOARD OF LICENSED DIABETES EDUCATORS
P.O. BOX 1360
FRANKFORT, KY 40602
http://bde.ky.gov

APPLICATION FOR LICENSURE

- A non-refundable application fee of $50.00 (fifty dollars) must be included with this application.
- Please make check or money order payable to the Kentucky State Treasurer. DO NOT SEND CASH.
- Please mail the completed application and the application fee to the address above.
- Print or type

Licensing Options (check one):

_____ Master – (CDE/BC-DAM)

- American Association of Diabetes Educators (AADE), Certified Diabetes Educator (CDE), or Board Certified in Advanced Diabetes Management (BC-ADM) (Attach certified copy of credential in good standing. Do not complete Pt. 2 & 3)

_____ Licensed

- Board approved course plus experiential requirement (Attach certified copy of course completion, complete Pts. 2 &3)

PART 1:

Name:
_____
Last First Middle

Address: _____
(Official address to be used by the Board for all correspondence)

City: _____ State: _____ Zip Code: _____

County: _____

Phone Number: _____ Work number: _____

Social Security Number: _____ Date of Birth: _____

Email Address: _____

Professional Discipline Information: _____
(fill in the blank)

Do you currently hold another professional license or credential? _____Yes _____ No
If yes, list the license(s) and the state in which you are licensed.
_____ _____
_____ _____

Have your credentials ever been disciplined? ____Yes _____No
If yes, please provide the violation and the discipline imposed_____
_____
_____

Have you ever been convicted or pled to a felony? _____Yes _____ No
If yes, explain and provide official court documentation of the resolution _____
_____
_____

PART 2:
Work Experience
(Make additional copies as necessary)

Applicant's name: _____

Job Title: _____

Department: _____

Institution/Practice Site: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Name of Immediate Supervisor: _____

Title of Immediate Supervisor: _____

1. Employment status: _____Yes, I am currently employed/self-employed in this position.
   _____ I am NOT currently employed/self- employed in this position.

2. Employment dates
   from month _____ day _____ year_____**to** month _____ day _____ year_____

3. For this job, I am claiming _____ hours per week in diabetes education. **Do not report hours as a range.**

4. I am claiming a **total of** _____ **hours** in diabetes self-management education for the employment dates listed above.

5. Practice setting (**check one only**):

   _____ Hospital Inpatient Only
   _____ Hospital Outpatient Only
   _____ Both Hospital Inpatient/Outpatient
   _____ Home Health Agency
   _____ Physician's Office
   _____ Community/Public Health Agency
   _____ Self-Employed/Private Practice
   _____ Other (specify) _____

6. If you answered "Other" to item 5, provide a description of the setting. Use a separate sheet of paper if necessary, and attach to application.
   _____
   _____

7. Delivery method for diabetes self-management training that you provide(d) in this job (**check one only**):
   _____ Face to face only _____ Electronic only (e.g., telephone, internet) _____Face to face and electronic

Supervisor Affidavit

I have reviewed the work experience portion of this application and attest that I meet the requirements to be a supervisor as set out in regulation and that to the best of my knowledge the applicant's work experience is accurate, complete and truthful.
(Make additional copies as necessary).

_____ _____
Signature Printed Name

Title: _____ Date Signed: _____

Department: _____

Institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Telephone: _____ Email Address: _____
(include area code)

DE-01 (6/2013)

PART 3:
SUPERVISION LOG PAGE

(Not required if application submitted prior to May 1, 2014)

A minimum of 750 hours of work experience within the last five years, with 250 of those hours being obtained within the last year preceding licensure application, are required.

"Supervisor" means a licensed diabetes educator in good standing as defined in KRS 309.325(3) or a master licensed diabetes educator in good standing as defined in KRS 309.325(4).

Clinical Supervisor's Name: _____

Professional Credentials: _____

Signature: _____

Number of Hours of Supervised Work Experience since last renewal: _____ Dates Obtained: _____

Telephone Number (Days only): _____

Additional Supervisor (if applicable):

Clinical Supervisor's Name: _____

Professional Credentials: _____

Signature: _____

Number of Hours of Supervised Work Experience since last renewal: _____ Dates Obtained: _____

Telephone Number (Days only): _____

Additional Supervisor (if applicable):

Clinical Supervisor's Name: _____

Professional Credentials: _____

Signature: _____

Number of Hours of Supervised Work Experience since last renewal: _____Dates Obtained: _____

Telephone Number (Days only): _____

Total Supervised Work Experience Hours: _____

Applicant Affidavit

I do hereby certify that under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that should an investigation at any time disclose any misrepresentation or falsification, my application could be rejected or my license revoked by the Board.

_____

Applicant's Signature **Date**

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